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ABSTRACT

An itinerant/consultant program in Colorado provides services to children with mild to severe emotional and behavior problems. Three Itinerant Behavior Development (IBD) teachers service 24 elementary and 5 middle schools. The program, which expanded from behavior management to include curriculum modifications, overcame early staff resistance and is now generally accepted. IBD teachers work with teachers of self contained classes to promote mainstreaming. Placement decisions are based on a level of intervention format. A case study of a 12 year old with behavioral and learning problems is presented to illustrate the IBD philosophy of intervention and involvement with other staff. (CL)

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The Vital Link:

Developing an Effective Continuum of Intervention

to Meet the Needs of Emotionally/Behaviorally Disordered Students

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The Cherry Creek School District is in the southeast portion of the Denver Metropolitan area. One of seven school districts in Arapahoe County, the 110-square mile District includes parts of unincorporated Arapahoe County, parts of the cities of Aurora, Englewood, and Greenwood Village, and all of the municipalities of Cherry Hills Village and Glendale.

There is no "city of" Cherry Creek. The District's name comes from the creek and valley that runs through the original population center of the District.

The Cherry Creek School District serves approximately 23,000 students encompassing 24 elementary, 5 middle, and 3 high schools with a middle to upper class population.

The Vital Link consists of an itinerant/consultant program forming the "vital link" in a continuum of services for those children described as exhibiting mild to severe emotional and behavioral problems. This program has two Itinerant Behavior Development teachers servicing the 24 elementary and 5 middle schools. The high schools have the I-team, Interdisciplinary Program, to meet similar needs.

Program Evolution

Increase in Staff

The program was piloted during the '80-'81 school year with one person as an itinerant with a goal of endoctrination and familiarization with the program's concept. The IBD, Itinerant Behavior Development, person would act as a facilitator to this process. The original IBD teacher was a former self-contained EBD, Emotional/Behavioral Development, teacher completing his PhD in psychology with experience as a school psychologist.

A second person was hired for the '81-'82 school year to meet a growing need. At this time the thrust was not just behavioral, but expanded to include curriculum modifications. The additional IBD person has a background that includes ex-

perience in regular education teaching, learning disabilities diagnostics and teaching, and consultation with coordination and delivery of services to students with a variety of exceptionalities.

Case load and types of cases served demand that a third IBD person be hired for the '83-'84 school year.

Primary Focus

The initial focus of the Itinerant Behavior Development program was behavior management, but has since expanded to include curriculum modification for students with special needs. Children and teachers in the regular classroom and a variety of special education classrooms may utilize the services of the IBD program through consultation, assessment, and direct intervention. Both people who are presently the itinerant/consultants have had regular and self-contained behavior development experience which may give an insightful perspective for intervention.

Level of Acceptance

Intitially there was some resistance to the IBD program from support staff, mental health staff, and administration regarding the model. Many administrators had concerns about one more person telling schools what to do. Their feeling was that we need a practical approach with someone who could work directly with the teachers and children. The mental health teams were perceiving the IBD program as a possible duplication of services and a confusion of roles.

A survey that was recently completed, winter of '83, with a 45% return rate reflects a high level of acceptance of the model and the individuals implementing it. When assessing the needs of the IBD program, most respondents agreed that some expansion of the program was required. This means hiring a third person so that more consistent and visible service can be maintained in the schools. In an appraisal of the services already provided, most felt that consultation to teachers and direct service to children were most valuable. Many mentioned the

assessment of children for self-contained placement as an asset of the IBD program. A few felt that a person outside of a particular building is not already locked into the system and could give a fresh perspective.

EBD Students to IBD Support

The self-contained EBD teachers can feel security in the knowledge that an IBD teacher will be involved in the mainstreaming process to aid both the child and the regular classroom teachers with strategies for a successful reintroduction to the regular classroom. This process may lend a higher success rate to those children attempting to fit into the mainstream. There seems to be a willingness for the self-contained EBD teachers to release their children from self-contained to itinerant support. The numbers of children leaving the self-contained EBD programs support this contention. Case loads are down in self-contained EBD programs and up in the IBD program. In February, 1981, the first year of the IBD program, there were 62 children staffed into the self-contained EBD classes and 5 staffed IBD at the elementary school level. In February, 1982 there were 54 children staffed into the self-contained EBD classes and 14 staffed IBD. February, 1983 showed a dramatic change in numbers with 52 children staffed self-contained EBD and 36 staffed IBD. It should be noted that during this period of time, February, 1981-1983, the Cherry Creek School District experienced a student population growth rate of approximately 7% per year.

Decreased Need for Self-contained Programming

The experience has been that a child was referred to the Behavior Development program with the expectation from the classroom teachers that the child would be transported magically and immediately to a place somewhere in "BD Magicland". The problem was either suppose to disappear from existence or have BD "fairy dust" sprinkled over it so the child became the model and was returned to that classroom

never to display problem behavior again.

This utopic ideal, as we all know too well, does not exist. One of the most difficult feats is to change an impression created through misinformation and/or desperation. Even for those children who are placed in self-contained EBD classrooms, the problems do not magically disappear, but rather, the child is taught to cope with the environment. Sometimes the child returns to the mainstream successfully, other times unsuccessfully, and there are those who never seem to return and may even go on to a more restrictive placement such as a residential treatment center.

The key is to implant the idea with the classroom teacher that, first, we need to consider the least restrictive placement and, second, there are more interventions that may be attempted before writing the child off to a self-contained EBD placement. The basis of an IBD consultative model is to work together with the classroom teachers, building administrator, mental health people, learning specialists, and parents to develop a plan of intervention that works for everyone involved.

It has been our experience that once a classroom teacher becomes involved with new interventions with the child there is a renewed commitment to have that child succeed. In the majority of cases the child has been successfully maintained in the regular classroom and the classroom teachers have had a positive experience in modifying behavior. In cases where the additional interventions, even on a consistent basis, have not worked it has been difficult for the teacher to remove those children to self-contained EBD programming. It seems that once a teacher commits to a renewed effort of intervention with the child, that teacher does not want to give it up. This process brings an awareness and understanding of strategies that may be used with other children that may exhibit behavior problems hopefully decreasing the need for self-contained programming.

A Process Based Model

Procedures for placement in self-contained EBD classes has evolved from a criterion based model to a process based model. In other words, we're not simply considering the existence of an emotional or behavioral condition that could precipitate self-contained placement, but using a continuum of interventions whether or not a child seems appropriate for self-contained placement.

A level of intervention format has been developed to meet this need. A referral for students with emotional or behavioral problems will first be made to the building special services team. Level I of the continuum of services requires that a member of the building special services team intervenes on a consultive basis. Parents are informed at this time, that special efforts are being made to help this child. Interventions are made with short term or intermittant direct or consultative services with the child, parents and teachers. If Level I intervention does not meet the needs of the student, the case is again brought to the special services team for consideration of a Level II intervention.

In all cases where a Level II intervention is being considered, the IBD teacher participates in the building special services team decision making process in developing an intervention assessment plan for the student. It is the responsibility of the building special services team to notify the IBD teacher well in advance of meetings where an itinerant staffing is being considered so that participation in team decision making can be completed in a knowledgeable manner. The special services team, IBD teacher, and other relevant school staff meet, at this time, to develop an intervention/assessment plan for the student. The assessment plan is designed to supplement current information. The assessment reports should indicate that the child's functioning has been investigated in the areas of: 1) educational, 2) communicative, 3) emotional, 4) health, 5) social, and 6) behavioral functioning. Parent permission is obtained, the assessment plan is carried out, and a staffing date is decided upon. A case manager is designated at the

staffing. This person will be responsible for coordinating and following the case. The case manager may be a member of the building special services team or the IBD teacher. Selection of a case manager is based upon the individual needs of the case. If Level II intervention proves insufficient, the special services team is again brought together for consideration of Level III intervention.

At Level III the emotional/behavioral functioning of the child is so severe that the child is a danger to himself and others or Level I and Level II interventions have already been attempted and found to be unsuccessful. The coordinator of BD programs is contacted and made aware of the consideration of placement in a self-contained EBD classroom. Placement in a Self-contained EBD classroom requires a thorough assessment investigating the child's functioning in the areas of: 1) educational, 2) communicative, 3) emotional, 4) health, 5) social, and 6) behavioral functioning. Parent permission is obtained and the assessment plan carried out. The staffing is held and self-contained placement is considered.

This process also applies to students returning to less severe programming, working their way from Level III, self-contained EBD, back through Levels II and I to a total mainstream situation with no support.

Case Study

In order to illustrate the continuum of interventions within the Emotional/Behavioral Disorder (EBD) referral process, a case study will be presented. The case study will focus on two aspects of the Itinerant Behavioral Development (IBD) philosophy: intervention and interfacing.

Background

Christopher is a 12 year old who is currently in fifth grade. He entered Cherry Creek School District as a third grader from a nearby district in September, 1980. Previous school records indicate that Chris had been retained in second grade. His overall intelligence was found to be in the above-average

range. He had mild visual perceptual deficits. His teacher received consultative support from a Learning Disabilities teacher for this weakness. In addition, Chris worked with a Speech/Language specialist for articulation therapy and the school Social Worker for self-concept skill development. He was staffed out of the L.D. and speech programs prior to coming to Cherry Creek.

The referral behaviors that were evident upon entering Cherry Creek included: difficulty with organizational skills, little task completion, daydreaming, little interest in relating to peers, and over-reacting to criticism by arguing and tantruming. At home, Chris's parents noted similar behavioral problems with the addition of being afraid of the dark and being left alone.

Chris was referred for Itinerant Behavioral Development services in September, 1981. The ongoing interventions were outside psychotherapy to reduce Chris's anxiety and fears and contracting in the classroom to encourage task completion and organizational skills. Although his interest in interacting with peers had increased, Chris was still not functioning well in the school setting.

Intervention

The overall goal at the intervention stage is to maintain students in the regular classroom thus decreasing the flow of students into self-contained classrooms. Chris had a number of behaviors requiring modification, yet it was felt by the referring teachers and social workers that IBD support was a viable option. During the intervention stage high risk students such as Chris are identified and strategies are implemented.

In this case Chris's contract was refined to include a definition of expected behaviors. For example, "attending to work" was individualized to include not playing with objects, starting a task within 2 minutes after directions are given, asking for help if needed, and not "spacing out". These are specific aspects of Chris's off-task behavior and it was discovered that by defining specifics, all or most loopholes were eliminated. This process was also a way to keep data on Chris on a daily basis.

Meeting curricular needs is also an important factor during this phase. Through IBD support, a child can be looked at diagnostically regarding academic strengths and weaknesses. Since the IBD teacher is working 1:1 with a student, much valuable information can be formulated. In Chris's case, it was noted that automatic processing skills were depressed under time limit situations. Also, visual memory was a weak area. Suggestions for curricular modifications were made to the teacher and Chris was given strategies to help him compensate. The planned "spill-over" effect hoped for at this point is to help increase the ability of the classroom teachers to effectively intervene with a broad spectrum of students. It was noted that other students were put on a similar contract as Chris. This early phase of intervention promotes and encourages teacher creativity.

Interfacing

The interfacing that evolves from the very start of the intervention phase, is a key element in the success of the itinerant programming. There is on-going involvement of the support staff within the school. The school social worker was the original case manager, therefore she was an integral part of general planning. The IBD teacher would keep her abreast of the case. The eventual goal is to wean the student away from IBD support back into the hands of a home

school staff member. In this case, the social worker would take this responsibility. There was frequent contact with both parents in this case. Chris's teacher would have weekly contact through a classroom system used for all students. The goal of the IBD teacher was to coordinate Chris's total programming. It was not unusual for the IBD teacher to call parents weekly or bi-monthly. She also took on responsibility for acting as liaison between school, parents, and therapist. The IBD teacher is not always case manager, but since she had direct contact with Chris, it worked best to have this role designation.

Support and Monitor

We will digress from the case at this point and describe the final two aspects of the continuum of interventions in the EBD referral process. If a student is unable to benefit from itinerant support after a wide range of interventions have been attempted, over a reasonable period of time, self-contained programming is usually the next option. The role of the itinerant at this point is to help facilitate the transition into a self-contained classroom, which usually precludes a change of school. The itinerant oftentimes has had direct involvement with the student and can help the receiving school in their initial planning phase. In addition, IBD can offer support to the parents prior to placement.

It's crucial to monitor the student's progress during this placement as all students leaving self-contained classes for Emotional/Behavior Disordered students are placed on itinerant status. Knowing this well in advance enables the self-contained teacher to be more willing to "wean" students on to a less restrictive placement.

Out-Take and Follow-Up

The search for the appropriate next step toward the least restrictive environment is facilitated jointly by the self-contained EBD teacher, psychologist and/or social worker and the itinerant BD teacher. The receiving teacher can be confident that she will be given direct support to ease the transition. One of the goals of the program is to have a systematic and formalized approach to follow-up. At this point a student is seen on a regular basis with the length of support decided on a case by case basis. The follow-up of students leaving restrictive settings offers support to student, the new setting, and parents. We can now see the program working in both directions with the common goal of helping students function successfully in the regular classroom environment.